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Emergencies, Disasters and Mass Casualty Medical Care

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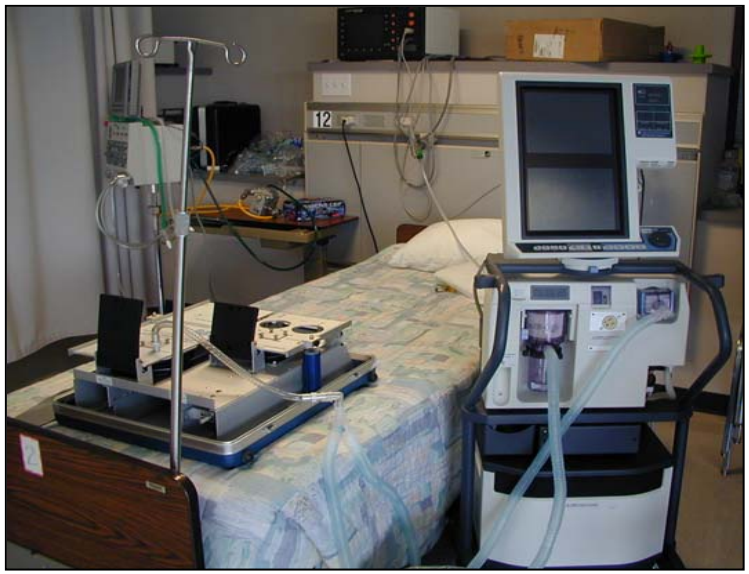
Let's set the stage…

- 1st wave of Pandemic Influenza
- 10% of population is sick
- 30-40% of hospital staff are absent from work
- Providers will have fully implemented their medical surge plans
  - Inpatient units are at "capacity"
  - Outpatient services are overwhelmed
- Providers are experiencing shortages in critical materials
  - Ventilators
  - Anti-virals
- Providers throughout the region/state facing same thing and cannot provide assistance or supplies
- Clinicians are saying that they don't have the resources to provide the traditional standard of care

"Something Has to Give"

What does this mean?

Health Care Providers will have to do a lot more with a lot less



- Ventilators
- Anti-virals
- Blood products
- Operating Rooms
- Hospital Beds
- Staff

This means providing care in a fundamentally different way

"Altered Standards of Care"

What does this mean?

- No accepted definition
- AHRQ
  - Allocation of scarce resources
  - Greatest good for the greatest number
- DHS
  - Fair distribution to achieve the greatest benefit
- JCAHO
  - Graceful degradation

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The AHRQ Approach

- *Providing Mass Medical Care with Scarce Resources: A Community Planning Guide* (November 2006)
- Follow-up to AHRQ's initial report on altered standards
- Target audience is "community planners" but also facility/community, State and Federal level planners
- Walks through various planning considerations, including allocation of scarce resources
- Themes:
  - Regional coordination and cooperation
  - Proactive planning, including surge and ACS
  - Communication between governments, first responders, hospitals and the public
  - Consideration of legal and ethical issues

The AHRQ Approach to Allocation of Scarce Resources

Implementing Clinical Changes to Respond to an MCE
EXAMPLES OF POSSIBLE RESPONSE PROCESSES

- The incident commander recognizes the need for systematic clinical changes.
- The planning chief gathers any guidelines, information, and resources.
- A clinical care committee (predetermined members and designees for toxic, infectious, and trauma situations) is convened. Members may include a hospital administrator, a hospital attorney, nursing supervisor, a respiratory care supervisor, a hospital ethicist, a community representative, and representatives from clinical departments.
- The clinical care committee reviews existing strategies/protocols and determines:
- Methods to meet patient care needs, location of care, assignment of resources
- Additional changes in staff responsibilities to redistribute specialized staff and incorporate other health care providers, lay providers, or family members
- A mechanism to reassess local/regional hospital efforts and needs and recommend changes on a regular basis
- Information is disseminated to inpatient services, outpatient services, the regional hospital coordination point, and State and local health departments.
- Security and behavioral health response plans are implemented.
- Triage plan is implemented to determine ED/outpatient screening of patients, patient discharge, removal from therapy, and bed assignments.
- Just-in-time training or education is implemented for health care workers, patients, and family members.

How is Virginia Preparing?

- VDH contracted with VHHA for VHHA to work on various issues using HRSA funds
- VHHA engaged Troutman Sanders on issues related to emergency and disaster preparedness
- Work Groups were created to address the top two priorities:
  - Altered Standards of Care
  - Human Resources

Altered Standards of Care Work Group

- Diverse representation from across the state
  - Hospitals
  - Providers
  - Emergency planners
  - Health Department
  - General Assembly
- Liability and logistics issues
- Legislative and non-legislative approaches

The Non-Legislative Approach
Standards vs. Process

- Two possible deliverables from work group:
  - Detailed standards and algorithms for determining treatment
  - Detailed process that hospitals can use to develop facility specific algorithms
- Work Group chose *process*
  - Consensus that VDH should not prescribe to hospitals how to provide care and use scarce resources
  - No “one size fits all” algorithm
  - Consistency in process was more reasonable than consistency in result

THE "CRITICAL RESOURCE SHORTAGE PLANNING GUIDE" HAS BEEN DEVELOPED BY THE VHHA WORK GROUP AS A PLANNING TOOL FOR VIRGINIA HOSPITALS

Definitions

- **Critical Resource:** those resources that are necessary to sustain human life, prevent permanent injury/disability, or stabilize a patient experiencing a medical emergency.
- **Critical Resource Shortage:** Critical Resource has been depleted, and all alternate methods of obtaining the Critical Resource have been exhausted, such that remaining resources will not allow a hospital to treat patients in accordance with the traditional standard of care.

Definitions

- **Critical Resource Shortage Response Plan:** that treatment protocol that is created in response to a critical resource shortage that is caused by an emergency or disaster, as defined in Title 44, pursuant to which scarce critical resources are allocated to do the most good for the greatest number of patients.
- **Emergency or Disaster:** those community and statewide emergencies and disasters that are encompassed in the definition in Title 44 of the Virginia Code.

Planning Guide Framework

- Pre-Event
  - Establish critical resource planning committee
  - Conduct critical resource vulnerability analysis
  - Establish baseline ethical principles to guide responses to a shortage
  - Develop critical resource response plans and triage protocols
  - Create mechanisms to operationalize intra-event ad hoc response plan development
  - Educate staff
  - Exercise/drill

Planning Guide Framework

- Intra-Event
  - Identify and confirm critical resource shortages
  - Activate existing critical resource response plans
  - Develop ad hoc critical resource response plans, if needed
  - Terminate critical resource response plans
- Post-Event
  - Provide support services to employees, staff and MDs
  - Evaluate critical resource response plans
  - Modify plans as needed

NEXT STEPS

Planning Guide roll out

- September 2006: VASHRM
- November 2006: HEMC
- December 2006: Ethics committee chairs
- January 2007: Northern Virginia hospital executives
- January 2007: Virginia Pandemic Influenza Advisory Committee
- January/February 2007: All Virginia hospitals
- Spring 2007-Other key constituencies